the Code, failure to sign the return under section 6695(b) of the Code, failure to furnish an identification number under section 6695(c) of the Code, failure to retain a copy or list under section 6695(d) of the Code, failure to file a correct information return under section 6695(e) of the Code, and negotiation of a check under section 6695(f) of the Code, in the manner stated in §1.6695–1 of this chapter.

(b) *Effective/applicability date.* This section is applicable to returns and claims for refund filed after December 31, 2008.

[T.D. 9436, 73 FR 78461, Dec. 22, 2008]

§56.6696–1 Claims for credit or refund by tax return preparers.

(a) *In general.* For rules relating to claims for credit or refund by a tax return preparer who prepared a return or claim for refund for tax under chapter 41 of subtitle D of the Internal Revenue Code, the rules under §1.6696–1 of this chapter will apply.

(b) *Effective/applicability date.* This section is applicable to returns and claims for refund filed, and advice provided, after December 31, 2008.

[T.D. 9436, 73 FR 78461, Dec. 22, 2008]

§56.7701–1 Tax return preparer.

(a) *In general.* For the definition of a tax return preparer, see §301.7701–15 of this chapter.

(b) *Effective/applicability date.* This section is applicable to returns and claims for refund filed, and advice provided, after December 31, 2008.

[T.D. 9436, 73 FR 78461, Dec. 22, 2008]

PART 57—HEALTH INSURANCE PROVIDERS FEE

Sec.

AUTHORITY: 26 U.S.C. 7805; sec. 9010, Pub. L. 111–148 (124 Stat. 119 (2010)).

Section 57.3 also issued under 26 U.S.C. 6071(a)

Section 57.7 also issued under 26 U.S.C. 6302(a).

Section 57.6302–1 also issued under 26 U.S.C. 6302(a).

SOURCE: T.D. 9643, 78 FR 71487, Nov. 29, 2013, unless otherwise noted.

§57.1 Overview.

(a) The regulations in this part are designated ''Health Insurance Providers Fee Regulations.''

(b) The regulations in this part provide guidance on the annual fee imposed on covered entities engaged in the business of providing health insurance by section 9010 of the Patient Protection and Affordable Care Act (PPACA), Public Law 111–148 (124 Stat. 119 (2010)), as amended by section 10905 of PPACA, and as further amended by section 1406 of the Health Care and Education Reconciliation Act of 2010, Public Law 111–152 (124 Stat. 1029 (2010)) (collectively, the Affordable Care Act or ACA). All references to section 9010 in this part 57 are references to section 9010 of the ACA. Unless otherwise indicated, all other references to subtitles, chapters, subchapters, and sections are references to subtitles, chapters, subchapters and sections in the Internal Revenue Code and the related regulations.

(c) Section 9010(e)(1) sets an applicable fee amount for each year, beginning with 2014, that will be apportioned among covered entities with aggregate net premiums written over $25 million for health insurance for United States health risks. Generally, each covered entity is liable for a fee in each fee year that is based on its net premiums written during the data year in an amount determined by the Internal Revenue Service (IRS) under the rules of this part.

§57.2 Explanation of terms.

(a) *In general.* This section explains the terms used in this part 57 for purposes of the fee.

(b) *Covered entity*—(1) *In general.* Except as provided in paragraph (b)(2) of this section, the term *covered entity* means any entity with net premiums written for health insurance for United

States health risks in the fee year if the entity is—

(i) A health insurance issuer within the meaning of section 9832(b)(2), defined in section 9832(b)(2) as an insurance company, insurance service, or insurance organization that is licensed to engage in the business of insurance in a State and that is subject to State law that regulates insurance (within the meaning of section 514(b)(2) of the Employee Retirement Income Security Act of 1974 (ERISA));

(ii) A health maintenance organization within the meaning of section 9832(b)(3), defined in section 9832(b)(3) as—

(A) A Federally qualified health maintenance organization (as defined in section 1301(a) of the Public Health Service Act);

(B) An organization recognized under State law as a health maintenance organization; or

(C) A similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization;

(iii) An insurance company subject to tax under part I or II of subchapter L, or that would be subject to tax under part I or II of subchapter L but for the entity being exempt from tax under section 501(a);

(iv) An entity that provides health insurance under Medicare Advantage, Medicare Part D, or Medicaid; or

(v) A multiple employer welfare arrangement (MEWA), within the meaning of section 3(40) of ERISA, to the extent not fully insured, provided that for this purpose a covered entity does not include a MEWA that with respect to the plan year ending with or within the section 9010 data year satisfies the requirements to be exempt from reporting under 29 CFR 2520.101–2(c)(2)(ii)(A), (B), or (C).

(2) *Exclusions*—(i) *Self-insured employer.* The term *covered entity* does not include any entity (including a voluntary employees' beneficiary association under section 501(c)(9) (VEBA)) that is part of a self-insured employer plan to the extent that such entity self-insures its employees' health risks. The term *self-insured employer* means an employer that sponsors a self-insured medical reimbursement plan within the meaning of §1.105–11(b)(1)(i) of this chapter. Self-insured medical reimbursement plans include plans that do not involve shifting risk to an unrelated third party as described in §1.105–11(b)(1)(ii) of this chapter. A self-insured medical reimbursement plan may use an insurance company or other third party to provide administrative or bookkeeping functions. For purposes of this section, the term *self-insured employer* does not include a MEWA.

(ii) *Governmental entity.* The term *covered entity* does not include any governmental entity. For this purpose, the term *governmental entity* means—

(A) The government of the United States;

(B) Any State or a political subdivision thereof (as defined for purposes of section 103) including, for example, a State health department or a State insurance commission;

(C) Any Indian tribal government (as defined in section 7701(a)(40)) or a subdivision thereof (determined in accordance with section 7871(d)); or

(D) Any agency or instrumentality of any of the foregoing.

(iii) *Certain nonprofit corporations.* The term *covered entity* does not include any entity—

(A) That is incorporated as a nonprofit corporation under a State law;

(B) No part of the net earnings of which inures to the benefit of any private shareholder or individual (within the meaning of §§1.501(a)–1(c) and 1.501(c)(3)–1(c)(2) of this chapter);

(C) No substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation (within the meaning of §1.501(c)(3)–1(c)(3)(ii) of this chapter) (or which is described in section 501(h)(3) and is not denied exemption under section 501(a) by reason of section 501(h));

(D) That does not participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of (or in opposition to) any candidate for public office (within the meaning of §1.501(c)(3)–1(c)(3)(iii) of this chapter); and

(E) More than 80 percent of the gross revenues of which is received from government programs that target low-income, elderly, or disabled populations under titles XVIII, XIX, and XXI of the Social Security Act.

(iv) *Certain voluntary employees' beneficiary associations (VEBAs).* The term *covered entity* does not include any entity that is described in section 501(c)(9) that is established by an entity (other than by an employer or employers) for purposes of providing health care benefits. This exclusion applies to a VEBA that is established by a union or established pursuant to a collective bargaining agreement and having a joint board of trustees (such as in the case of a multiemployer plan within the meaning of section 3(37) of ERISA or a single-employer plan described in section 302(c)(5) of the Labor Management Relations Act, 29 U.S.C. 186(c)(5)). This exclusion does not apply to a MEWA.

(3) *State.* Solely for purposes of paragraph (b) of this section, the term *State* means any of the 50 States, the District of Columbia, or any of the possessions of the United States, including American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the Virgin Islands.

(c) *Controlled groups*—(1) *In general.* The term *controlled group* means a group of two or more persons, including at least one person that is a covered entity, that is treated as a single employer under section 52(a), 52(b), 414(m), or 414(o).

(2) *Treatment of controlled group.* A controlled group (as defined in paragraph (c)(1) of this section) is treated as a single covered entity for purposes of the fee.

(3) *Special rules.* For purposes of paragraph (c)(1) of this section (related to controlled groups)—

(i) A foreign entity subject to tax under section 881 is included within a controlled group under section 52(a) or (b); and

(ii) A person is treated as being a member of the controlled group if it is a member of the group at the end of the day on December 31st of the data year.

(d) *Data year.* The term *data year* means the calendar year immediately before the fee year. Thus, for example, 2013 is the data year for fee year 2014.

(e) *Designated entity*—(1) *In general.* The term *designated entity* means the person within a controlled group that is designated to act on behalf of the controlled group regarding the fee with respect to—

(i) Filing Form 8963, ''Report of Health Insurance Provider Information'';

(ii) Receiving IRS communications about the fee for the group;

(iii) Filing a corrected Form 8963 for the group, if applicable, as described in §57.6; and

(iv) Paying the fee for the group to the government.

(2) *Selection of designated entity*—(i) *In general.* Except as provided in paragraph (e)(2)(ii) of this section, each controlled group must select a designated entity by having that entity file the Form 8963 in accordance with the form instructions. The designated entity must state under penalties of perjury that all persons that provide health insurance for United States health risks that are members of the group have consented to the selection of the designated entity. Each member of a controlled group must maintain a record of its consent to the controlled group's selection of the designated entity. The designated entity must maintain a record of all member consents.

(ii) *Requirement for consolidated groups; common parent.* If a controlled group, without regard to foreign corporations included under section 9010(c)(3)(B), is also an affiliated group the common parent of which files a consolidated return for Federal income tax purposes, the designated entity is the agent for the group (within the meaning of §1.1502–77 of this chapter) for the data year.

(iii) *Failure to select a designated entity.* Excepted as provided in paragraph (e)(2)(ii) of this section, if a controlled group fails to select a designated entity as provided in paragraph (e)(2)(i) of this section, then the IRS will select a member of the controlled group to be the designated entity. If the IRS selects the designated entity, then all members of the controlled group that provide health insurance for a United States health risk will be deemed to

have consented to the IRS's selection of the designated entity.

(f) *Fee*. The term *fee* means the fee imposed by section 9010 on each covered entity engaged in the business of providing health insurance.

(g) *Fee year*. The term *fee year* means the calendar year in which the fee must be paid to the government. The first fee year is 2014.

(h) *Health insurance*—(1) *In general*. Except as provided in paragraph (h)(2) of this section, the term *health insurance* generally has the same meaning as the term *health insurance coverage* in section 9832(b)(1)(A), defined to mean benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract, when these benefits are offered by an entity that is one of the types of entities described in paragraph (b)(1)(i) through (b)(1)(v) of this section. The term *health insurance* includes limited scope dental and vision benefits under section 9832(c)(2)(A) and retiree-only health insurance.

(2) *Exclusions*. The term *health insurance* does not include—

(i) Coverage only for accident, or disability income insurance, or any combination thereof, within the meaning of section 9832(c)(1)(A);

(ii) Coverage issued as a supplement to liability insurance within the meaning of section 9832(c)(1)(B);

(iii) Liability insurance, including general liability insurance and automobile liability insurance, within the meaning of section 9832(c)(1)(C);

(iv) Workers' compensation or similar insurance within the meaning of section 9832(c)(1)(D);

(v) Automobile medical payment insurance within the meaning of section 9832(c)(1)(E);

(vi) Credit-only insurance within the meaning of section 9832(c)(1)(F);

(vii) Coverage for on-site medical clinics within the meaning of section 9832(c)(1)(G);

(viii) Other insurance coverage that is similar to the insurance coverage in paragraph (h)(2)(i) through (vii) of this section under which benefits for medical care are secondary or incidental to other insurance benefits, within the meaning of section 9832(c)(1)(H), to the extent such insurance coverage is specified in regulations under section 9832(c)(1)(H);

(ix) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof, within the meaning of section 9832(c)(2)(B), and such other similar, limited benefits to the extent such benefits are specified in regulations under section 9832(c)(2)(C);

(x) Coverage only for a specified disease or illness within the meaning of section 9832(c)(3)(A);

(xi) Hospital indemnity or other fixed indemnity insurance within the meaning of section 9832(c)(3)(B);

(xii) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act), coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code, and similar supplemental coverage provided to coverage under a group health plan, within the meaning of section 9832(c)(4);

(xiii) Coverage under an employee assistance plan, a disease management plan, or a wellness plan, if the benefits provided under the plan constitute excepted benefits under section 9832(c)(2) (or do not otherwise provide benefits consisting of health insurance under paragraph (h)(1) of this section);

(xiv) Student administrative health fee arrangements, as defined in paragraph (h)(3);

(xv) Travel insurance, as defined in paragraph (h)(4) of this section; or

(xvi) Indemnity reinsurance, as defined in paragraph (h)(5)(i) of this section.

(3) *Student administrative health fee arrangement*. For purposes of paragraph (h)(2)(xiv) of this section, the term *student administrative health fee arrangement* means an arrangement under which an educational institution, other than through an insured arrangement, charges student administrative health fees to students on a periodic basis to help cover the cost of student health clinic operations and care delivery (regardless of whether the student uses the clinic and regardless of whether the

student purchases any available student health insurance coverage).

(4) *Travel insurance.* For purposes of paragraph (h)(2)(xv) of this section, the term *travel insurance* means insurance coverage for personal risks incident to planned travel, which may include, but is not limited to, interruption or cancellation of trip or event, loss of baggage or personal effects, damages to accommodations or rental vehicles, and sickness, accident, disability, or death occurring during travel, provided that the health benefits are not offered on a stand-alone basis and are incidental to other coverage. For this purpose, the term *travel insurance* does not include major medical plans that provide comprehensive medical protection for travelers with trips lasting 6 months or longer, including, for example, those working overseas as an expatriate or military personnel being deployed.

(5) *Reinsurance*—(i) *Indemnity reinsurance.* For purposes of paragraphs (h)(2)(xvi) and (k) of this section, the term *indemnity reinsurance* means an agreement between one or more reinsuring companies and a covered entity under which—

(A) The reinsuring company agrees to accept, and to indemnify the issuing company for, all or part of the risk of loss under policies specified in the agreement; and

(B) The covered entity retains its liability to, and its contractual relationship with, the individuals whose health risks are insured under the policies specified in the agreement.

(ii) *Assumption reinsurance.* For purposes of paragraph (k) of this section, the term *assumption reinsurance* means reinsurance for which there is a novation and the reinsurer takes over the entire risk of loss pursuant to a new contract.

(i) *Located in the United States.* The term *located in the United States* means present in the United States (within the meaning of paragraph (m) of this section) under section 7701(b)(7) (for presence in the 50 States and the District of Columbia) or §1.937–1(c)(3)(i) of this chapter (for presence in a possession of the United States).

(j) *NAIC.* The term *NAIC* means the National Association of Insurance Commissioners.

(k) *Net premiums written*—The term *net premiums written* means premiums written, including reinsurance premiums written, reduced by reinsurance ceded, and reduced by ceding commissions and medical loss ratio (MLR) rebates with respect to the data year. For this purpose, MLR rebates are computed on an accrual basis in determining net premiums written. Because indemnity reinsurance within the meaning of paragraph (h)(5)(i) of this section is not health insurance under paragraph (h)(1) of this section, the term *net premiums written* does not include premiums written for indemnity reinsurance and is not reduced by indemnity reinsurance ceded. However, in the case of assumption reinsurance within the meaning of paragraph (h)(5)(ii) of this section, the term *net premiums written* does include premiums written for assumption reinsurance and is reduced by assumption reinsurance premiums ceded.

(l) *SHCE.* The term *SHCE* means the Supplemental Health Care Exhibit. The SHCE is a form published by the NAIC that most covered entities are required to file annually under State law.

(m) *United States.* For purposes of paragraph (i) of this section, the term *United States* means the 50 States, the District of Columbia, and any possession of the United States, including American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the Virgin Islands.

(n) *United States health risk.* The term *United States health risk* means the health risk of any individual who is—

(1) A United States citizen;

(2) A resident of the United States (within the meaning of section 7701(b)(1)(A)); or

(3) Located in the United States (within the meaning of paragraph (i) of this section) during the period such individual is so located.

§57.3 Reporting requirements and associated penalties.

(a) *Reporting requirement*—(1) *In general.* Annually, each covered entity, including each controlled group that is treated as a single covered entity,

must report its net premiums written for health insurance of United States health risks during the data year to the IRS by April 15th of the fee year on Form 8963, ''Report of Health Insurance Provider Information,'' in accordance with the instructions for the form. A covered entity that has net premiums written during the data year is subject to this reporting requirement even if it does not have any amount taken into account as described in § 57.4(a)(4). If an entity is not in the business of providing health insurance for any United States health risk in the fee year, it is not a covered entity and does not have to report.

(2) *Manner of reporting.* The IRS may provide rules in guidance published in the Internal Revenue Bulletin for the manner of reporting by a covered entity under this section, including rules for reporting by a designated entity on behalf of a controlled group that is treated as a single covered entity.

(3) *Disclosure of reported information.* Pursuant to section 9010(g)(4), the information reported on each original and corrected Form 8963 will be open for public inspection or available upon request.

(b) *Penalties*—(1) *Failure to report*—(i) *In general.* A covered entity that fails to timely submit a report containing the information required by paragraph (a) of this section is liable for a failure to report penalty in the amount described in paragraph (b)(1)(ii) of this section in addition to its fee liability and any other applicable penalty, unless the failure is due to reasonable cause as defined in paragraph (b)(1)(iii) of this section.

(ii) *Amount.* The amount of the failure to report penalty described in paragraph (b)(1)(i) of this section is—

(A) $10,000, plus

(B) The lesser of—

(*1*) An amount equal to $1,000 multiplied by the number of days during which such failure continues; or

(*2*) The amount of the covered entity's fee for which the report was required.

(iii) *Reasonable cause.* The failure to report penalty described in paragraph (b)(1)(i) of this section is waived if the failure is due to reasonable cause. A failure is due to reasonable cause if the covered entity exercised ordinary business care and prudence and was nevertheless unable to submit the report within the prescribed time. In determining whether the covered entity was unable to submit the report timely despite the exercise of ordinary business care and prudence, the IRS will consider all the facts and circumstances surrounding the failure to submit the report.

(iv) *Treatment of penalty.* The failure to report penalty described in this paragraph (b)(1)—

(A) Is treated as a penalty under subtitle F;

(B) Must be paid on notice and demand by the IRS and in the same manner as a tax under the Internal Revenue Code; and

(C) Is a penalty for which only civil actions for refund under procedures of subtitle F apply.

(2) *Accuracy-related penalty*—(i) *In general.* A covered entity that understates its net premiums written for health insurance of United States health risks in the report required under paragraph (a)(1) of this section is liable for an accuracy-related penalty in the amount described in paragraph (b)(2)(ii) of this section, in addition to its fee liability and any other applicable penalty.

(ii) *Amount.* The amount of the accuracy-related penalty described in paragraph (b)(2)(i) of this section is the excess of—

(A) The amount of the covered entity's fee for the fee year that the IRS determines should have been paid in the absence of any understatement; over

(B) The amount of the covered entity's fee for the fee year that the IRS determined based on the understatement.

(iii) *Understatement.* An understatement of a covered entity's net premiums written for health insurance of United States health risks is the difference between the amount of net premiums written that the covered entity reported and the amount of net premiums written that the IRS determines the covered entity should have reported.

(iv) *Treatment of penalty.* The accuracy-related penalty is subject to the

provisions of subtitle F that apply to assessable penalties imposed under chapter 68.

(3) *Controlled groups.* Each member of a controlled group that is required to provide information to the controlled group's designated entity for purposes of the report required to be submitted by the designated entity on behalf of the controlled group is jointly and severally liable for any penalties described in this paragraph (b) for any reporting failures by the designated entity.

§ 57.4 Fee calculation.

(a) *Fee components*—(1) *In general.* For every fee year, the IRS will calculate a covered entity's allocated fee as described in this section.

(2) *Calculation of net premiums written.* Each covered entity's allocated fee for any fee year is equal to an amount that bears the same ratio to the applicable amount as the covered entity's net premiums written for health insurance of United States health risks during the data year taken into account bears to the aggregate net premiums written for health insurance of United States health risks of all covered entities during the data year taken into account.

(3) *Applicable amount.* The applicable amounts for fee years are—

Fee year	Applicable amount
2014	$8,000,000,000
2015	$11,300,000,000
2016	$11,300,000,000
2017	$13,900,000,000
2018	$14,300,000,000
2019 and thereafter	The applicable amount in the preceding fee year increased by the rate of premium growth (within the meaning of section 36B(b)(3)(A)(ii)).

(4) *Net premiums written taken into account*—(i) *In general.* A covered entity's net premiums written for health insurance of United States health risks during any data year are taken into account as follows:

Covered entity's net premiums written during the data year that are:	Percentage of net premiums written taken into account is:
Not more than $25,000,000	0
More than $25,000,000 but not more than $50,000,000	50
More than $50,000,000	100

(ii) *Controlled groups.* In the case of a controlled group, paragraph (a)(4)(i) of this section applies to all net premiums written for health insurance of United States health risks during the data year, in the aggregate, of the entire controlled group, except that any net premiums written by any member of the controlled group that is a nonprofit corporation meeting the requirements of § 57.2(b)(2)(iii) or a voluntary employees' beneficiary association meeting the requirements of § 57.2(b)(2)(iv) are not taken into account.

(iii) *Partial exclusion for certain exempt activities.* After the application of paragraph (a)(4)(i) of this section, if the covered entity (or any member of a controlled group treated as a single covered entity) is exempt from Federal income tax under section 501(a) and is described in section 501(c)(3), (4), (26), or (29) as of December 31st of the data year, then only 50 percent of its remaining net premiums written for health insurance of United States health risks that are attributable to its exempt activities (and not to activities of an unrelated trade or business as defined in section 513) during the data year are taken into account. If an entity to which this partial exclusion applies is a member of a controlled group, then the partial exclusion applies to that entity after first applying paragraph (a)(4)(i) on a pro rata basis to all members of the controlled group.

(b) *Determination of net premiums written*—(1) *In general.* The IRS will determine net premiums written for health insurance of United States health risks

for each covered entity based on the Form 8963, ''Report of Health Insurance Provider Information,'' submitted by each covered entity, together with any other source of information available to the IRS. Other sources of information that the IRS may use to determine net premiums written for each covered entity include the SHCE, which supplements the annual statement filed with the NAIC pursuant to State law, the annual statement itself or the Accident and Health Policy Experience filed with the NAIC, the MLR Annual Reporting Form filed with the Center for Medicare & Medicaid Services' Center for Consumer Information and Insurance Oversight of the U.S. Department of Health and Human Services, or any similar statements filed with the NAIC, with any State government, or with the Federal government pursuant to applicable State or Federal requirements.

(2) *Presumption for United States health risks.* For any covered entity that files the SHCE with the NAIC, the entire amount reported on the SHCE as direct premiums written will be considered to be for health insurance of United States health risks as described in § 57.2(n) (subject to any applicable exclusions for amounts that are not health insurance as described in § 57.2(h)(2)) unless the covered entity can demonstrate otherwise.

(c) *Determination of amounts taken into account.* (1) For each fee year and for each covered entity, the IRS will calculate the net premiums written for health insurance of United States health risks taken into account during the data year. The resulting number is the numerator of the fraction described in paragraph (d)(1) of this section.

(2) For each fee year, the IRS will calculate the aggregate net premiums written for health insurance of United States health risks taken into account for all covered entities during the data year. The resulting number is the denominator of the fraction described in paragraph (d)(2) of this section.

(d) *Allocated fee calculated.* For each covered entity for each fee year, the IRS will calculate the covered entity's allocated fee by multiplying the applicable amount from paragraph (a)(3) of this section by a fraction—

(1) The numerator of which is the covered entity's net premiums written for health insurance of United States health risks during the data year taken into account (described in paragraph (c)(1) of this section); and

(2) The denominator of which is the aggregate net premiums written for health insurance of United States health risks for all covered entities during the data year taken into account (described in paragraph (c)(2) of this section).

§ 57.5 Notice of preliminary fee calculation.

(a) *Content of notice.* Each fee year, the IRS will make a preliminary calculation of the fee for each covered entity as described in § 57.4. The IRS will notify each covered entity of its preliminary fee calculation for that fee year. The notification to a covered entity of its preliminary fee calculation will include—

(1) The covered entity's allocated fee;

(2) The covered entity's net premiums written for health insurance of United States health risks;

(3) The covered entity's net premiums written for health insurance of United States health risks taken into account after the application of § 57.4(a)(4);

(4) The aggregate net premiums written for health insurance of United States health risks taken into account for all covered entities; and

(5) Instructions for how to submit a corrected Form 8963, ''Report of Health Insurance Provider Information,'' to correct any errors through the error correction process.

(b) *Timing of notice.* The IRS will specify in other guidance published in the Internal Revenue Bulletin the date by which it will send each covered entity a notice of its preliminary fee calculation.

§ 57.6 Error correction process.

(a) *In general.* Upon receipt of its preliminary fee calculation, each covered entity must review this calculation during the error correction period. If the covered entity identifies one or more errors in its preliminary fee calculation, the covered entity must timely submit to the IRS a corrected Form

8963, ''Report of Health Insurance Provider Information,'' during the error correction period. The corrected Form 8963 will replace the original Form 8963 for all purposes, including for the purpose of determining whether an accuracy-related penalty applies, except that a covered entity remains subject to the failure to report penalty if it fails to timely submit the original Form 8963. In the case of a controlled group, if the preliminary fee calculation for the controlled group contains one or more errors, the corrected Form 8963 must include all of the required information for the entire controlled group, including members that do not have corrections.

(b) *Time and manner*. The IRS will specify in other guidance published in the Internal Revenue Bulletin the time and manner by which a covered entity must submit a corrected Form 8963. The IRS will provide its final determination regarding the covered entity's submission no later than the time the IRS provides a covered entity with a final fee calculation.

(c) *Finality*. Covered entities must assert any basis for contesting their preliminary fee calculation during the error correction period. In the interest of providing finality to the fee calculation process, the IRS will not accept a corrected Form 8963 after the end of the error correction period or alter final fee calculations on the basis of information provided after the end of the error correction period.

§57.7 Notification and fee payment.

(a) *Content of notice*. Each fee year, the IRS will make a final calculation of the fee for each covered entity as described in §57.4. The IRS will base its final fee calculation on each covered entity's original or corrected Form 8963, ''Report of Health Insurance Provider Information,'' as adjusted by other sources of information described in §57.4(b)(1). The notification to a covered entity of its final fee calculation will include—

(1) The covered entity's allocated fee;

(2) The covered entity's net premiums written for health insurance of United States health risks;

(3) The covered entity's net premiums written for health insurance of United States health risks taken into account after the application of §57.4(a)(4);

(4) The aggregate net premiums written for health insurance of United States health risks taken into account for all covered entities; and

(5) The final determination on the covered entity's corrected Form 8963, ''Report of Health Insurance Provider Information,'' if any.

(b) *Timing of notice*. The IRS will send each covered entity a notice of its final fee calculation by August 31st of the fee year.

(c) *Differences in preliminary fee calculation and final calculation*. A covered entity's final fee calculation may differ from the covered entity's preliminary fee calculation because of changes made pursuant to the error correction process described in §57.6 or because the IRS discovered additional information relevant to the fee calculation through other information sources as described in §57.4(b)(1). Even if a covered entity did not file a corrected Form 8963 described in §57.6, a covered entity's final fee may differ from a covered entity's preliminary fee because of information discovered about that covered entity through other information sources. In addition, a change in aggregate net premiums written for health insurance of United States health risks can affect every covered entity's fee because each covered entity's fee is equal to a fraction of the aggregate fee collected from all covered entities.

(d) *Payment of final fee*. Each covered entity must pay its final fee by September 30th of the fee year. For a controlled group, the payment must be made using the designated entity's Employer Identification Number as reported on Form 8963. The fee must be paid by electronic funds transfer as required by §57.6302–1. There is no tax return to be filed with the payment of the fee.

(e) *Controlled groups*. In the case of a controlled group that is liable for the fee, all members of the controlled group are jointly and severally liable for the fee. Accordingly, if a controlled group's fee is not paid, the IRS may separately assess each member of the controlled group for the full amount of the controlled group's fee.

§ 57.8 Tax treatment of fee.

(a) *Treatment as an excise tax.* The fee is treated as an excise tax for purposes of subtitle F (sections 6001–7874). Thus, references in subtitle F to ''taxes imposed by this title,'' ''internal revenue tax,'' and similar references, are also references to the fee. For example, the fee is assessed (section 6201), collected (sections 6301, 6321, and 6331), enforced (section 7602), and subject to examination and summons (section 7602) in the same manner as taxes imposed by the Code.

(b) *Deficiency procedures.* The deficiency procedures of sections 6211–6216 do not apply to the fee.

(c) *Limitation on assessment.* The IRS must assess the amount of the fee for any fee year within three years of September 30th of that fee year.

(d) *Application of section 275.* The fee is treated as a tax described in section 275(a)(6) (relating to taxes for which no deduction is allowed).

§ 57.9 Refund claims.

Any claim for a refund of the fee must be made by the entity that paid the fee to the government and must be made on Form 843, ''Claim for Refund and Request for Abatement,'' in accordance with the instructions for that form.

§ 57.10 Effective/applicability date.

Sections 57.1 through 57.9 apply to any fee that is due on or after September 30, 2014.

§ 57.6302–1 Method of paying the health insurance providers fee.

(a) *Fee to be paid by electronic funds transfer.* Under the authority of section 6302(a), the fee imposed on covered entities engaged in the business of providing health insurance for United States health risks under section 9010 and § 57.4 must be paid by electronic funds transfer as defined in § 31.6302–1(h)(4)(i) of this chapter, as if the fee were a depository tax. For the time for paying the fee, see § 57.7.

(b) *Effective/Applicability date.* This section applies with respect to any fee that is due on or after September 30, 2014.

PART 141—TEMPORARY EXCISE TAX REGULATIONS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

§ 141.4975–13 Definition of "amount involved" and "correction".

Until superseded by permanent regulations under sections 4975(f) (4) and (5), § 53.4941(e)–1 of this chapter (Foundation Excise Tax Regulations) will be controlling to the extent such regulations describe terms appearing both in section 4941(e) and section 4975(f). Because of the need for immediate guidance with respect to the provisions contained in this Treasury decision, it is found impracticable to issue it with notice and public procedure thereon under subsection (b) of section 553 of title 5 of the United States Code or subject to the effective date limitation of subsection (d) of that section.

(Sec. 7805 of the Internal Revenue Code of 1954 (68A Stat. 917; 26 U.S.C. 7805))

[T.D. 7425, 41 FR 32890, Aug. 6, 1976, as amended by T.D. 8084, 51 FR 16305, May 2, 1986]

PART 143—TEMPORARY EXCISE TAX REGULATIONS UNDER THE TAX REFORM ACT OF 1969

Sec.

AUTHORITY: Sec. 7805, 68A Stat. 917; 26 U.S.C. 7805.

§ 143.1 [Reserved]

§ 143.2 Taxes on self-dealing; scholarship and fellowship grants by private foundations.

(a) *In general.* Section 4941(d)(1)(D) of the Internal Revenue Code of 1954 as added by section 101(b) of the Tax Reform Act of 1969 (83 Stat. 500) provides that the term ''self-dealing'' includes